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Social Work Services: How can Social Workers Improve the Healthcare Experience for People who are Homeless?

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SOCIAL WORK SERVICES: HOW CAN SOCIAL WORKERS IMPROVE THE
HEALTHCARE EXPERIENCE FOR PEOPLE WHO ARE HOMELESS?

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
McKinsey Sue Ann Kemp

June 2018

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ABSTRACT

This research project focuses on how social workers can improve the healthcare experience for people who are homeless. The twelve participants in this study were recruited from a homeless shelter located in Southern California. Data was collected for this study using qualitative methods by means of interviews. Interviews were conducted in person, audio recorded, and then transcribed for data analysis. Findings from this study indicated that the concepts of time, perception of needs being met, service connection, staff interaction, social work intervention, and potential social work intervention were all connected to whether participants viewed their healthcare visit as a negative experience or a positive experience. In addition, findings from this study revealed a low percentage of reported social work encounters at healthcare facilities among study participants. Results from this study have implications for social work practice in regards to location of social work intervention at healthcare facilities and extension of social work roles in healthcare settings.

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CHAPTER ONE

ASSESSMENT

Introduction

Chapter one starts with a focus on the research topic of this study; how can social workers improve the healthcare experience for people who are homeless. Next is an explanation of post positivism, the chosen paradigm for this study. Following this is a literature review focused on the role of social workers in healthcare settings, homelessness in the medical setting, and on barriers homeless individuals encounter when accessing healthcare services. After this the theoretical orientation of this study is addressed. Finally, this chapter discusses what implications this study has for micro and macro social work practice.

Research Focus

The research focus of this study is on how social workers can improve the healthcare experience for people who are homeless. The “healthcare experience” for the purpose of this research project is defined as the overall experience from admission to discharge for an individual while being treated as an in or out patient in a healthcare setting.

The Affordable Care Act (ACA) was signed by President Barack Obama in March of 2010 with full implementation occurring in 2015. This piece of federal legislation had a significant impact on healthcare and healthcare delivery. The

changes brought forth by the ACA not only increased the number of insured patients, but also increased the capability for social workers to make an impact on the healthcare experience for patients. Even with the expansion of insurance coverage the ACA provided, there are still barriers to accessibility of healthcare services that exist for the homeless population. Individuals who are homeless face barriers such as lack of healthcare insurance, preconceived conceptions of homelessness among healthcare workers, and inability to access medications and other necessary resources.

This study addresses the role of social workers in healthcare settings. The healthcare system is ever changing and, with it, the role of social workers in healthcare settings. When the role of the social worker changes so do the interventions that they utilize when working with patients. The role of the social worker and the interventions they use can impact patients' outcome and their healthcare experience. For example, if the social worker is in a role that allows them to intervene with patients upon admission in the healthcare settings, then perhaps more patients could be assessed for resource needs. This could increase the likelihood for follow through of discharge instructions and could reduce the need for revisits.

Paradigm and Rationale for Chosen Paradigm

This research study was conducted using the post positivist paradigm. The post positivist paradigm uses an inductive approach and qualitative research methods. This study did not start with a hypothesis, but rather a theory

developed during the study. This perspective allowed the study to actively develop as data was gathered, analyzed, and reassessed. This perspective allowed the researcher to develop themes from the data gathered. The data that was gathered determined the direction of the study.

The post positivist paradigm was chosen for this study because of its inductive approach. The social problem was identified and through interviews that were conducted in a natural environment, a better understanding of the problem was developed because other influences were observed (Morris, 2014). Interviewing individuals who are homeless about their experiences in healthcare settings allowed the researcher to see the problem through their perspective by means of shared thoughts and feelings. This was not measured by quantitative means, but analyzed to find common themes in their experiences. This in turn created a more encompassing picture of the focus problem. The qualitative methods used in the post positivist paradigm allowed for themes to be discovered from data gathered through shared experiences. These themes increased the understanding of the focus problem, assisted in identifying interventions, and highlighted the implications this study has for micro and macro social work practice in the areas of healthcare and homelessness.

Literature Review

This literature review starts with a focus on the role of social workers in healthcare settings. Next is a look at the experiences of people who are

homeless in medical settings. Finally, barriers that individuals who are homeless face in healthcare settings are highlighted.

The Role of Social Workers in the Healthcare Setting

As society evolves so does the perception of healthcare resulting in changes in the role of the social worker in healthcare settings. Healthcare facilities strive to be patient-centric, meaning that decisions made about the patient's care revolves around the patient's needs and best interest. While this remains the idea behind patient care in healthcare settings, the cost of healthcare has been rising in the United States since the 1940's with significant cost increases beginning in the 1980's (Stevens, 2008), resulting in different approaches to reduce costs.

Discharging a patient in a timely manner is a method used in managing costs. Therefore, the makeup of an interdisciplinary discharge team plays a vital role in healthcare settings. The social worker in many acute healthcare settings plays an important role on this team in expediting the discharge of patients. One study found that social workers who specified this as a role spent 60% or more of their time devoted to completing tasks associated with patient discharges (Judd & Sheffield, 2010). Tasks that were noted with the role of discharge planner included discharge placement assistance and that of linking patients with necessary outside resources. These are important tasks in ensuring that patients are discharged in a timely manner for cost efficiency. This is further emphasized by the findings in Judd and Sheffield's (2010) study that reimbursement and cost

efficiency in addition to optimal patient outcome has evolved as a priority in healthcare settings. As a result, the role of the social worker in healthcare settings has evolved to meet this change.

The need for the role of a social worker on an interdisciplinary team is further emphasized in the medical home model. The purpose of the medical home model is to treat a patient holistically in one location. Allen (2012) contend that the “Medical home model must include a social lens that considers the whole person in the context of the person’s whole environment” (p.183). The social worker as part of an interdisciplinary team can contribute to this perspective. In this role, the social worker goes beyond discharge planner to play a more holistic part in the patient-centric focus of healthcare.

Another role of social workers in healthcare settings is that of a patient navigator. Tasks that align with this role include assistance with obtainment of necessary resources in and out of the healthcare facility to help the patient reach their optimal outcome. These tasks help reduce the likelihood of readmission and revisits by ensuring that all of the needs of the patient are met before and after discharge. One study found that the “purpose of patient navigation is to eliminate the barriers that vulnerable patients encounter in the timely diagnosis and treatment of medical conditions” (Browne et al., 2015, p. 158). By being part of this team the social worker contributes to the reduction in delay of care and increases the likelihood of an appropriate discharge.

Another aspect in regards to the role of the social worker in healthcare settings to consider is where the social worker intervenes with the patients. As previously mentioned, as part of an interdisciplinary team, the social worker plays an active role in the discharge of patients. With the social worker focused on ensuring timely efficient discharges, some patients who could benefit from their assistance are missed. Patients who are seen in an out-patient setting often do not receive the consultation of a social worker. Yet, many patients who enter a healthcare setting could benefit from the expertise of a social worker. One study found that in emergency rooms, “many of the patients had high levels of social needs,” and that, “homeless individuals made 83.6 ED visits per 100 homeless persons” (Moore, Eckman, & Shumway, 2012, p.140-141). Even with the high number of social needs among the patients seen in emergency rooms, this study also found that the rate of social services referrals were only 0.7% (Moore, Eckman, & Shumway, 2012). Some patients who seek medical treatment in healthcare settings are treated for the presenting medical condition and discharged without their social needs being addressed – even when identified as in need of social service resources.

Homelessness in Medical Settings

Research has found that “individuals experiencing homelessness are hospitalized at higher rates than housed individuals” (Feigal et al., 2014, p. 1033). In addition, studies have shown that patients who are homeless tend to remain hospitalized after being medically cleared longer than those who have

adequate housing (Feigal et al., 2014). Many patients are treated then discharged back to the streets or shelters rather than to adequate housing for recuperation. In addition to increased lengths of stay this has also been attributed as a cause for revisits and readmissions of people who are homeless to healthcare settings such as hospitals. This has led to a negative perception by healthcare staff of patients who are homeless and who frequent healthcare settings more often. This can result in patients being “referred to as ‘revolving door’ or ‘frequent flyer’” (Fader & Phillips, 2012, p. 99).

In addition, individuals who are homeless often suffer from medical conditions that are chronic, such as diabetes and Hepatitis C. These conditions require ongoing treatment in order to maintain healthy stabilization of the condition (Bharel et al., 2013). Homeless patients often lack the resources needed to follow through with recommended care that is part of the discharge plan. In addition, when a patient is seen in the emergency room the immediate health issue is often addressed or stabilized and the person is discharged without an assessment of the underlying issue (Fader & Phillips, 2012).

Barriers to Healthcare

Individuals who are homeless encounter barriers in accessing healthcare resources needed to reach their optimal health outcome. With the passing of the Affordable Care Act (ACA), some barriers, such as access to healthcare insurance, were decreased. Some barriers that existed before the passing of the ACA still persist regardless of this advancement. Four barriers to accessing

these resources are identified in one study as inability to fulfill basic needs, cost of healthcare, lack of resources, and lack of compassion from those providing care (Nickasch & Marnocha, 2009). The study found that, regardless of seeking medical attention or not, if basic needs were not met then the health issue would not be resolved. Therefore, if a person who is homeless seeks medical attention for pneumonia the illness will not be resolved if the person does not have access to shelter and other basic needs. This has also been found true in regards to the barrier of high cost. A person who is homeless may be able to seek medical attention, but may not have the ability to pay for the medication prescribed.

In addition, a study conducted in Hawaii, where rates of insured homeless are high, found that there were still significant healthcare needs of the homeless that were not being met (Hoside et al., 2011). This study found that the main barrier was financial even among those who have health insurance. Another barrier is lack of access to physicians and free clinics. As a result the only choice for health care may be an emergency room; if one is in the area. Use of an emergency room is a costly way to seek care. In addition, an emergency care team often treats the presenting medical condition without addressing the underlying issues.

Lack of compassion shown to patients who are homeless by those caring for them is another barrier. One study found that lack of compassion on behalf of the staff helped negatively shape the perception of healthcare services for homeless participants (Nickasch & Marnocha, 2009).

The literature review for this study addresses social worker roles in healthcare settings, homelessness in medical settings, and barriers to healthcare for individuals who are homeless. It is apparent that healthcare has evolved overtime and along with it the role of the social worker. The current role of the medical social worker seems to focus more around the discharge plan of patients. In addition, people who are homeless face many barriers in accessing healthcare, such as preconceived conceptions, lack of financial resources, and inadequate continued care programs after discharge. This leads to questions that are addressed in this study about adjustments that can be made to the role of the social worker to help improve the healthcare experience of the homeless population they serve.

Theoretical Orientation

Systems theory is the theoretical orientation for this study. Systems theory looks at how the interworking's of a system influences human behavior (Andreae, 2011). Society is a large system that influences and is influenced by the sub-systems within it. Healthcare is a sub-system within society and differs based on the social system in which it exists. How this system functions affects those who access it. In some societies, such as those found in Brazil or the United Kingdom, healthcare is viewed as a human right. Therefore, a form of universal healthcare is established allowing access to those within that society (Duncan, Bertolozzi, Cowley, Egry, Chiesa, and De Siqueira França, 2015). In the United States, healthcare is viewed more as a commodity than a human right. As a

result, the cost of healthcare has risen and subsequently medical expenses are the top reason people file for bankruptcy in the United States.

In addition, sub-systems within our society contribute to the creation and perpetuation of homelessness. One sub-system that does this is the economic system (Lee, Tyler, & Wright, 2010). Inequality in access to economic resources is an indication of failure in this system. Economic factors that contribute to homelessness include poverty, low earning wages, lack of affordable housing, and lack of available employment (Lee, Tyler, & Wright, 2010). When the system fails to function appropriately those who utilize it suffer the consequences. According to the systems theory, systems interact on the macro, mezzo, and micro level (Andreae, 2011). Therefore using the systems theory for this study allowed for areas of concern to be identified and addressed in both micro and macro social work practice.

Contribution of Study to Micro and Macro Social Work Practice

This study has the potential for contributions to social work practice on both the micro and macro level. On the micro level, findings from this study offer new insight on practices that will allow social workers to intervene earlier with patients who are homeless. This will help to ensure their social needs are being assessed. Also, this study identifies areas in staff diversity training that could be improved through education programs. On a macro level, findings from this study help to identify areas of concern for healthcare and housing. Findings from this

study identify areas that are in need of advocating for new policies in the workplace and for new legislation.

Summary

This chapter addressed the research topic: how social workers can improve the healthcare experience for individuals who are homeless. It also discussed post positivism as the paradigm that was used for this study. In addition, the literature review examined research conducted on the role of social workers in healthcare settings, homelessness in medical settings, and barriers to healthcare for individuals who are homeless for a better understanding of the research topic. Systems theory was then identified as the theoretical orientation for this study. Finally, chapter one concluded with a review of potential contributions this study has on micro and macro social work practice.

CHAPTER TWO

ENGAGEMENT

Introduction

Chapter two focuses on the engagement stage of the study. It begins with the logistics of the study in regards to the study site and gate keeper of the site. This is followed by the researcher's self-preparation for the study. Next ethical, diversity, and political issues of the study will be discussed. Chapter two will conclude with the role technology played in the study.

Research Site

This study focused on a county in Southern California. The study site was at an agency that serves clients who are homeless. This is a non-profit organization, which offers programs for the community in the areas of housing, behavioral health, childcare, employment, and outreach. This agency is the largest in its region and serves around 1,500 clients each year. The agency serves men, women, and children through emergency shelter services and transitional housing. This agency is staffed with both paid workers and volunteers, who are dedicated to serving their client population using a holistic approach. The focus of this agency is to help their clients overcome life's obstacles in order to rebuild and restore stable, productive lives. For the purpose of this study, emergency shelters for families and single men and women were the point of contact for participants. Participants varied based on gender,

ethnicity, and age. The population of people who are homeless in the region of the agency are predominantly male, mostly between the ages of fifty and sixty-one, and Caucasian is the majority ethnic group (Department of Social Services, 2015). While this agency serves clients under the age of eighteen, for this study, all participants were at least eighteen years of age.

Engagement Strategies for Gatekeepers at Research Site

Engagement of the gatekeeper at the site, which serves clients who are homeless followed, the agency's established process. Engagement began with an email to the agency's volunteer department or designated gatekeeper. An overview of the study was provided at this time. This included the purpose of the study, the time period in which the site and participants would need to be accessed, and what assistance was needed from the gatekeeper. Once an acceptance email was received, a volunteer application was completed, as this is part of the agency's process. In person contact after initial gatekeeper engagement was determined based on the gate keeper's availability. Written consent to access the study site was obtained via email from the gatekeeper.

Self-Preparation

Prior to the start of the data gathering process, a literature review was conducted on the role of social workers in healthcare settings. This was done to establish basic knowledge of what the current roles are. A literature review was also conducted to address what current research has found to be the barriers

individuals who are homeless face in accessing healthcare services. Examples of barriers that were explored included inadequate healthcare insurance coverage, healthcare workers perceptions of patients who are homeless, and lack of access to necessary resources. Finally, a literature review on homelessness in medical settings was executed in order to discover what the experiences have reportedly been in the medical settings thus far for people who are homeless. In addition, demographics on age, gender, and race of the clients this agency serves were obtained. This was completed so that basic knowledge of the participant population could be developed. This will also done to assist with participant engagement and rapport building.

Diversity Issues

Diversity issues that were considered during this study included the differences in socioeconomic class, ethnicity, cultural norms, gender, and age between the participants and the researcher. Statistics on the homeless population in the region of the study site show that the average homeless person in this area is male, Caucasian, and between the ages of fifty and sixty-one (DPSS, 2015). The researcher differs from the population majority by gender and age. In addition, research shows that the homeless population in the region also consists of individuals from diverse ethnic backgrounds, including African American, Hispanic, American Indian, and Asian (DPSS, 2015). All of these races differ from the race of the researcher, which was another diversity issue. Finally, the social-economic status of the researcher differed from the study

participants. These diversity issues could have been an inhibitor in the rapport building and data collection processes. This could have resulted in the participants being less willing to participate or share information during the interview. The first step taken in addressing these diversity issues was the acknowledgement of them.

Awareness of these issues resulted in the researcher engaging the participants based on their individuality and unique life experiences. Awareness that each participant has their own story and their own history helped to address the diversity issues and assisted in the engagement and rapport building processes. Finally, the self-preparation process helped with these diversity issues, too, as the steps taken increased the researcher's knowledge of the diverse participant population.

Ethical Issues

In order to avoid ethical issues, this study was submitted to the Institutional Review Board (IRB) for approval. An ethical issue considered for this study was that the participants could have had concerns that their responses might have detrimental consequences for them. As a means of maintaining confidentiality, the researcher did not collect identifiable information about participants to be used in the study. Study codes were used in data journals for any identification purposes. Gender and age were noted for demographic data and study codes were used for interview transcriptions. In addition, the name of the study site and the precise location of the site were not included. Interviews

were recorded using an audio digital recorder. The interviews were then transcribed into Microsoft Word documents using Dragon Speak Naturally transcription software. Following transcription, the interview Word documents were saved onto an encrypted thumb drive. These recordings were deleted from the digital recorder after they were transcribed. All data saved onto the thumb drive will be disposed of by erasing them one year after the finalization of this research paper.

Informed consent was an important piece of the engagement process. Each participant was provided with a consent form prior to the interview. The method for maintaining confidentiality was outlined in the consent form. The informed consent also described the purpose of the study in detail. The researcher answered any questions participants had about the study and confidentiality.

Political Issues

Based on the differences in diversity it was likely that the life experiences of the researcher differed from those of the study participants. As a result, the worldview of the researcher most likely differed too. The interviews were conducted in order to learn about the participant's experiences based on their perceptions. A political issue that arose was that the participants wanted the study to focus on what they felt was the most important part of the experience. This could have resulted in the participants' responses focusing only on this topic and not addressing other aspects of the experience. For example, some

participants felt that experiences at the shelter's health clinic should be focused on. As a result, their responses revolved around their shelter experience at times versus their whole healthcare experience. The researcher needed to be sensitive to this difference in worldviews, but also needed to find methods to collect data on the entire experience. A way that the researcher addressed this was by acknowledging the participants' concerns while asking for more details about the rest of the experience. As addressed by Morris (2014), "The post positivist can consult with participants but he or she keeps the power to decide which data shall be collected and how data will be used" (p. 1713). It was important that the researcher remained aware of this while conducting the interviews and while completing the analysis process.

The Role of Technology in Engagement

Technology was used in the engagement process through telephone calls and emails. The initial contact with the gatekeepers was through an email followed by a phone call. A follow up informational email was sent next with a request for a meeting. A face to face meeting was preferred, but an online system such as FUZE was also an option.

Summary

Chapter two started with a discussion on the study site and engagement strategies that were used for site access. It was followed by a section focused on the researcher's self-preparation. Next, diversity, ethical, and political issues that

evolved during the study were discussed. Chapter two concluded with a summary of what role technology played in the engagement process.

CHAPTER THREE

IMPLEMENTATION

Introduction

This portion of the paper is an outline of the data gathering methodology that was used in this study. First, who the study participants were and what the selection process for the study participants was is explained. Next, the method of data collection that was used and what the phases of the data collection process were are discussed. This is followed by an outline on how the data was recorded and analyzed.

Study Participants

Participants in this study included individuals who were living in a homeless shelter located in a Southern California county. The sample size for this study was twelve. Participants included individuals who were homeless at the time of the study and who have visited a healthcare facility at least once in a year. Participants who were unsure of whether or not they encountered a social worker during their visit were included, along with those who knew they had encountered a social worker. The participants who were unsure whether they had encountered a social worker in the healthcare setting were included in the study due to the fact that their perceptions about how it might have impacted their healthcare experience would be of value in answering the research question. Participants only included those individuals who were residing in a

homeless shelter at the time of the research study. The most recent homeless count showed that there are an estimated 1,587 homeless individuals in this region (DPSS, 2015). Of those who participated in the DPSS survey, 25% reported as female, 68% as male, and 6% didn't report (DPSS 2015).

Participants in the current study were both male and female, with slightly more female participants. Given that there is a significantly larger population of males who are homeless in this area, the gender makeup of the current study does not reflect the larger population.

Regarding race, the majority of homeless individuals in this region are White, followed by Hispanic, African American, American Indian, and Asian (DPSS 2015). The current study was comprised of participants from different races and age groups, including African American and Caucasian. Thus, the current study does not closely resemble the larger population. The differences in gender and ethnicity, among this study's participants and individuals identified in the DPSS survey, could be explained by the fact that the DPSS survey included individuals who were sheltered and those who were not, where this study only included participants who were sheltered.

In addition, the majority of homeless individuals in the region are between the ages of 30 and 61, with the largest number being between 50 and 61 years of age (DPSS 2015). All participants in the current study were at least 18 years of age; the range was from 19 to 62.

Selection of Participants

This study used critical case sampling to select the study participants. Critical case sampling is when a researcher selects participants who will most likely be representative of the target population (Morris 2014). Since this study is using a critical case sample, participants needed to have visited a healthcare setting at least once in a year. This helped to increase the likelihood that relevant data would be obtained from participants' interviews. This form of sampling was also selected to meet time constraints and to avoid barriers in identifying potential participants due to Health Insurance Probability and Accountability Act (HIPAA) regulations. HIPPA protects private health information about patients. If a list of participants were identified based on medical history, it would require extensive and timely IRB approval. Following the critical case sampling method avoided this. A flyer was posted at the partnering agency to recruit potential participants. Participant criteria along with the dates and times that the researcher would be at the agency to conduct interviews were included on the flyer (see Appendix C). In addition, a private room was used so participants could ask questions about the study and be interviewed. The researcher accessed the site to gather data twice between the dates of August 16th and August 21st, 2017 for two hours each time. These dates and times were established by the agency gatekeeper.

Data Gathering

The method of data collection used for this study was semi-structured interviews. Prior to conducting the interview the researcher explained the study to the interviewee and obtained their written consent to participate in the study. A structured list of questions was developed to be administered in each interview. The interview questions were not limited to those on the list, as changes arose during the data gathering process. Thus, these were semi-structured interviews. Questions were asked with the purpose of identifying themes and categories among the data during the analysis process.

Several descriptive questions were asked, such as: Can you describe your experience as a patient at the healthcare facility? Structured questions were also used during the interview. For example: Did the social worker affect your experience at the health care facility? In addition, the list of questions included contrast questions, such as: How did the social worker make your experience at the healthcare facility better/worse? The various forms of questions were used to help identify patterns and categories in the data (see Appendix A).

Phases of Data Collection

In preparation for the interview a set of questions were developed based on the three phases in the interview process. The first phase was the beginning or engagement phase. The engagement phase consisted of more general questions. These were asked first in order to engage the participant and to increase their level of comfort. An example of this type of question was: Have

you ever been to a healthcare facility? The next phase was the middle or developing portion of the interview. During this phase the essential questions which focused on the research topic were asked. An example of this type of question was: Can you tell me about your interactions with the staff at the healthcare facility? The final stage of the interview was the termination stage. Questions that were asked in the termination stage were chosen to decrease the level of intensity. These were demographic questions, which the participants were more comfortable answering at the end. An example was: What is your age? At the end of the interview the participant was given a chance to add missed information or clarify information.

Data Recording

An audio digital voice recorder was used to record the interviews. Written consent was obtained from the interviewee to use this recording method prior to starting the interview. This was included in the consent process. Interview notes were typed on a laptop computer into a Microsoft Word document upon the conclusion of the interview for the one participant who did not consent to being voice recorded. Also there were two journals maintained; one for the research data notes and the other for the researcher's perceptions.

Data Analysis Procedures

The bottom up approach was used in the data analysis portion of this study. There were three phases of coding that transpired; first open coding, then

axial coding, followed by selective coding. The analysis process was concluded with the conditional matrix. During the open coding process, the transcribed interviews were broken down into portions to be further analyzed. This process allowed for pertinent information to be retained and the filler parts of the interviews to be set aside. Each portion was taken apart, further analyzed, and separated into different categories or concepts. The next stage was axial coding. During this part of the coding process, connections began to emerge and themes were developed. The third coding stage was selective coding. At this point, the theory was explained using a narrative on the relationship discovered in the open and axial coding processes. All aspects of the process and how the processes operated were considered when developing the theory. The final stage was the conditional matrix. This portion of the analysis process determined how the findings impact social work practice on the micro and macro levels.

Summary

Chapter three started with a focus on the study participants and the selection process for participants. This was followed by an explanation of the data gathering process and the phases of data collection. Next, how the data were recorded and analyzed was described in detail.

CHAPTER FOUR

EVALUATION

Introduction

This chapter starts with a description of participant demographics. This is followed by a breakdown of the concepts discovered during the open coding stage of analysis. Then themes developed during the axial coding stage are explained. Next, the data interpretations are discussed. The chapter concludes with a discussion of how the study findings can affect social work practice on both the micro and macro levels.

Data Analysis

Participant Demographics

There were a total of twelve participants in this study. Participants ranged in age from 19 to 62 and the average participant age was 41. Almost 60% of participants were female and about 40% were male. Nearly 60% of participants identified as African American and almost 40% identified as Caucasian. All participants reported having some form of health insurance coverage. About 92% reported having Medi-Cal (Medicaid) and 8% reported receiving Veteran health benefits. Study participants reported seeking healthcare services at hospitals, clinics, and urgent cares. Hospitals were frequented most by participants with a reported 92% seeking services at this type of healthcare facility. Frequency of visits to healthcare facilities by participants ranged from once a year to once

every two weeks. It is also important to note that about 40% of participants reported having an encounter with a social worker while at a healthcare facility. Nearly 60% of participants who reported not encountering a social worker conveyed that a social worker could have had an impact on their healthcare experience, had they encountered one.

During open coding, the first stage of data analysis, the following concepts were identified: time, perception of needs being met, service connection, staff interactions, social work intervention, and potential social work intervention. The researcher further analyzed these concepts in the next stage, axial coding. During the axial coding process the researcher found a connection between these concepts and the participants' perceptions of their healthcare experience. The two main themes that resulted from this connection were positive healthcare experiences and negative healthcare experiences.

Open Coding

Time. When asked to describe their healthcare experiences, several participants brought up the concept of time as a factor that affected their experience. For the purpose of this study the concept of "time" is in relation to the period the participant spent waiting to be seen, evaluated, or treated by a healthcare professional during their visit. Some participants described their wait time as a positive aspect while others described it as a negative one. Participant #12 described the wait time as positive, stating,

...they were amazing; they want to talk to me and find out, you know, they get you on the fast track and they get you in there find out what you need. And, you know, if you need something they order it right away, x-ray, anything, it's done right away. (personal communication, August 2017)

Another participant described the wait time as a negative aspect of their visit. Participant #3 stated that, "you have to wait hours just to be seen and their fast track isn't any faster" (personal communication, August 2017). Participant #1 described their wait time experience at one healthcare facility as, "being seen pretty fast instead of having to wait hours and hours" (personal communication, August 2017), but at another facility as, "it's just that they take forever to see you" (personal communication, August 2017).

Perceptions of Needs Being Met. Another common concept identified from the participant interviews during the open coding process was the participants' perceptions of their needs being met while at the healthcare facility. For the purpose of this study, perception of needs being met refers to whether or not the participant felt their issues and concerns were addressed during their visit. Several participants discussed their perception of their needs being met and how this affected their experience. Some participants reported that they felt their needs were addressed while others felt that they were not. When asked to describe the healthcare experience, participant #7 stated, "Well, umm, they took care of my physical and emotional needs" (personal communication, August 2017). Participant #8 reiterated this sentiment of needs being met, "I quit

smoking, so, they did help me here. They gave me a month's worth of patches so I could quit. And it's worked, it's worked for me real well" (personal communication, August 2017). Participant #4 stated that "they got the job done, got me ready to go, directed me where I needed to be" (personal communication, August 2017). Other participants reported that they did not feel like their needs were met. For example, participant #1 stated, "It's just with their fast track, it seems like you can't get your answers, they just say 'go back to your doctor' " (personal communication, August 2017). Participant #10 also described perceptions of needs not being met during a healthcare visit, stating, "It was also negative because they didn't get me the help that I needed. They just sent me out the door and told me to go to primary care" (personal communication, August 2017)

Service Connection. During the open coding process, the researcher identified another concept – service connection – from the participant interviews. For the purpose of this study, the term service connection refers to whether or not the participant was given resource information or connected with needed services at the time of their visit. Some participants reported that they were connected with services during their visit, some reported that they were not, and others did not include this in the description of their healthcare visit. When asked about social work encounters at the healthcare facility, participant #12 stated,

...asked them if they had social workers. They didn't, but the doctor printed me out this place and some other resources. That's why I ended

up here was from the doctor. He cared enough to take time and go print up all these things for me. (personal communication, August 2017)

Participant #3 described one of their visits as,

A lot of times there is not follow-up, they just tell you to go to your primary doctor but it can take a long time to get an appointment. So sometimes they don't really tell you what's going on. I had my son at the emergency room for a burn on his leg from a cup of soup here at the shelter. He was hungry and didn't want to wait for it to cool down. They gave me medicine for his leg and we were seen pretty quickly. Now they want me to take him to see a burn specialist ... but I don't have a car so I have to find a way to get him there. (personal communication, August 2017)

When asked to describe their healthcare experience, participant #1 stated, "And then it's like I can't book an appointment for my doctor so can you at least tell me where I can do research or something like that?" (personal communication, August 2017).

Staff Interactions. A concept that emerged during the first stage of open coding was that of participant interaction with staff while at the healthcare facility. For the purpose of this study, the concept of staff interactions relates to any interaction a study participant had with a staff member while being seen, evaluated, or receiving treatment at a healthcare facility. When asked to describe their interactions with staff at healthcare facilities, participants reported both positive and negative interactions. Participant #11 described a positive staff

interaction as “they were helping ten people at once, you know, just but they were still happy. I mean they still had a smile on their face” (personal communication, August 2017). Other participants also briefly described their staff interactions as positive. Participant #7 stated, “it’s been good” (personal communication, August 2017) and participant #6 reported, “They’re very pleasant enough” (personal communication, August 2017).

However, not all staff interactions reported were positive. Participant #3 stated that, “the staff were having side conversations when they should have been assessing our needs” (personal communication, August 2017). Participant #2 described their staff interaction as “even being an overflow people, you know, they need more of better management of, you know, asking personal questions in a waiting room, you know, is not exactly, you know, my idea of privacy” (personal communication, August 2017).

Social Work Intervention. During the open coding process, social work intervention was another concept identified by the researcher among the participant interviews. For the purpose of this study, the concept of social work intervention means actual interventions reported by participants who encountered social workers that impacted their healthcare experience. Not all participants reported encountering a social worker during their healthcare visits, but, of those who did, all shared how this encounter improved their visit. This is how participant #3 described their social work intervention: “The one I saw... helped me with a bus pass when I didn’t have bus fare” (personal

communication, August 2017) and participant #11 stated “They help me get a bus pass, um, they help me, uh, get home. Um, if I needed any help. They’re pretty good” (personal communication, August 2017).

Participant #6 stated, “Of course they check for, well, you know, housing or reference support... yeah they did” (personal communication, August 2017).

Participant #7 reported the following as their social worker intervention: “She tried to get me somewhere to go to stay instead of being homeless” (personal communication, August 2017). Participant number #8 conveyed their experience as, “They just gave me information on how to, uh, like get help and all that” (personal communication, August 2017).

Overall, participants who encountered a social worker perceived the encounter as helpful and positive. One participant in particular (participant #11) expressed that social work services are readily accessible in the healthcare facility they frequently visit: “Yeah all the time, whenever I go” (personal communication, August 2017).

Potential Social Work Intervention. During the open coding process, the concept of potential social work intervention was identified. Of the participants who did not encounter a social worker during their healthcare visit (60%), several reported feeling that a social worker could have positively impacted their experience, had they encountered one. For the purpose of this study, potential social work intervention refers to ways in which the participant felt an encounter with a social worker could have impacted their healthcare experience.

Participant #1 described potential social work intervention as, “maybe the social worker couldn’t they, like, explain what’s available for you?” (personal communication, August 2017). When asked to describe how a social worker could have impacted their experience, participant #5 asserted that a social work could help by making the healthcare environment friendlier for other homeless individuals. As this participant stated,

I’m pretty sure if I would have talked to a social worker I may have given her some insight into something may of made her much more approachable for the next person down the line, you know what I mean? Or more comfortable where the person felt more comfortable with in that line, so, I think it might, I mean, I feel every little bit helps, you know what I mean, nothing beats a fair even try. (personal communication, August 2017)

Participant #10 described several possible forms of social work intervention, including advocacy to help individuals obtain needed services. This participant stated, “I thought that a social worker was supposed to get the story. And find a way to advocate for you and find solutions and things to help you through the process or to get you resources to help” (personal communication, August 2017).

Of the participants who did not encounter a social worker, none expressed the belief that seeing a social worker would have been a detriment to their healthcare visit.

Axial Coding

During the axial coding stage of analysis, the researcher further analyzed the concepts identified in open coding. During this stage, the researcher discovered that the concepts were connected to two overarching themes: positive healthcare experiences and negative healthcare experiences. It was discovered when analyzing the concepts that time, perception of needs being met, service connection, staff interaction, social work intervention, and potential social work intervention were all connected to whether the participant viewed their healthcare visit as a negative experience or a positive experience.

Participants who described a negative healthcare experience discussed long wait times at the healthcare facility, viewed their needs as not being met during their visit, identified having poor staff interactions, and conveyed a lack of service connection. Participant #3 described their negative experience as, “the waits were long and the staff were having side conversations when they should have been assessing our needs” (personal communication, August 2017). These concepts also had a negative effect on the healthcare experience of participant #10 who stated, “it was also negative because they didn’t get me the help that I needed. They just sent me out the door and told me to go to primary care” (personal communication, August 2017).

Participants who discussed a positive healthcare experience reported having shorter wait times, perceived their needs as being met, reported being connected with services, described positive staff interactions, and conveyed

having social worker intervention. Participant #7 reported they had a positive experience because, “well umm they took care of my physical and emotional needs” (personal communication, August 2017). Participant # 4 described staff interactions that influenced their experience positively as “They got the job done got me ready to go directed me where I needed to be” (personal communication, August 2017). Participant #1 reported that time played a role in their positive experience described as “umm being seen pretty fast instead of having to wait hours and hours” (personal communication, August 2017). Participant # 7 stated, “she tried to get me somewhere to go to stay instead of being homeless” (personal communication, August 2017) to describe how social worker intervention had a positive impact on their healthcare experience. In addition, most of the participants who did not encounter a social worker reported that they felt social work intervention could have impacted their healthcare experience. Participant #1 described how they thought social work intervention could have impacted their healthcare experience in this way, “maybe the social worker couldn’t they like explain what’s available for you” (personal communication, August 2017). Therefore, the concept of potential social worker intervention can also be connected to the theme of positive healthcare experience.

Data Interpretation

This study found that time, perception of needs being met, service connection, staff interactions, social work interventions, and potential social work interventions were all factors that affected how participants perceived their health

care experience. These concepts were discovered based on data analysis of interviews conducted with participants who are homeless, where they shared their thoughts and feelings about their healthcare experiences. It is also important to note that all participants resided in a homeless shelter at the time the study was conducted.

Time was one concept that emerged as a factor noted by participants to contribute to whether or not they perceived their healthcare experience as positive or negative. This concept is a new contribution in this area, as few studies have examined it as a contributing factor. A study conducted in Australia on healthcare services for people who are homeless did briefly mention the concept of time in their study when they acknowledged that long wait times contributed to patients leaving the facility without completion of recommended medical treatment (Moore, Manias, & Gerdtz, 2011). For participants in this study, those who had relatively short wait times to be seen, evaluated, and treated viewed time as a positive aspect of their experience. Those who experienced long wait times perceived this concept as a negative factor.

The effect of time on participant's healthcare experience perception could be explained by its relevant importance to those living in a homeless shelter. Homeless shelters have set intake times, in addition to set times when clients must enter and exit the shelter. Time spent outside of the shelter can be valuable to clients as this is their time to work, inquire about employment, make scheduled appointments, and visit with family or friends, among addressing other needs.

Long wait times at medical facilities can take up a portion – if not all – of the independent time they are allotted. In addition, if the wait time exceeds the intake time at the shelter, eligibility of late admittance could be a concern. Time can also impact a client's ability to access safe and affordable transportation back to the shelter should late admittance be allowed. Another way in which time can be seen as an important factor is if the client has children. Clients with children may need to pick them up from school or day care by a particular time. Long wait times at a medical facility could impede their ability to accomplish this.

Perception of needs being met was another concept that emerged during this study as a contributing factor to participants' perception of their experience. Some participants shared feelings of dissatisfaction in regards to their needs not being met during their healthcare visit. These participants indicated this as a negative aspect of their experience. Others shared experiences of having their needs addressed during their visit resulting in a more satisfying healthcare experience. Regardless of the reason for the visit, they all articulated that there was some form of healthcare necessity that prompted their visit. Some reported that they felt this need had been met and associated this with a positive healthcare experience. They shared that this was accomplished via their healthcare issue being resolved or through the provision of education on how to address the need. Others expressed feelings of frustration over these needs not being met. Some even noted that they felt like they were not given answers or means of obtaining resolution for the issue. Others stated that they were

instructed to follow-up with their regular healthcare provider to have the issue resolved. This can be problematic for individuals who are homeless and lack access to transportation or who do not have an assigned primary doctor. If the individual is in transition and new to the area, they may not yet be connected with a primary doctor or medical group in the area. As with other healthcare consumers, individuals who are homeless enter a healthcare facility seeking some form of help. The participants' opinions on whether or not their needs were addressed strongly affected their perceptions of their overall healthcare experience.

Service connection can be a means of addressing a client's needs and was another factor identified in this study that contributed to participants' perceptions of their healthcare experience. Service connection take the form of referral to different organizations that provide services needed by the client or information on community resources that could be beneficial to the client. Participants in this study noted being connected with resources specifically in the areas of housing and transportation. Those who reported being connected with these services attributed this factor to their positive healthcare experience. Other participants reported that they were not connected with needed services and considered this to be a factor in their negative healthcare experience. Several participants in this study noted that, while they were in need of help with service connection to access referred services, they did not receive this assistance. One participant shared that they were referred to a specialist, but did not have the

means of reaching this specialist. This lack of resource connection resulted in the participant not being capable of following through with the discharge instructions. Another participant needed assistance connecting with a primary physician for instructed follow-up, but did not receive this service. Both participants reported that this lack of service connection had a negative impact on their experience. A previous study conducted on barriers to accessing healthcare services noted resource connection to be a barrier that individuals who are homeless encounter (Nichasch & Marnocha, 2009). The concept of service connection, as an identified barrier to healthcare services, can affect an individual's opinion of their healthcare experience based on whether or not they perceived this as being appropriately addressed during their visit.

The current study found staff interactions to be a factor that impacted participants' healthcare experiences. Participants indicated that interactions with staff in which they were treated kindly and in which staff had a pleasant demeanor had a positive impact on their healthcare experience. Previous studies have identified that people who are homeless visit medical facilities such as hospital emergency rooms at high rates (Moore, Manias, & Gerdtz, 2011). Visits to medical facilities by participants in this study were as frequent as once every two weeks. Revisits to healthcare facilities have been found to have a negative effect on healthcare provider's perceptions of individuals who are homeless (Fader & Phillips, 2012). However, participants in this study who indicated negative staff interactions noted reasons such as staff not focused on helping

them or staff not maintaining their privacy. The difference could be that participants of this study are sheltered. Participants in this study have access to food, shelter, facilities for showering, and a place for personal grooming. In addition, some participants also had access to laundry facilities within the shelter. Most participants were visibly well kempt in regards to personal grooming. As a result, negative staff perceptions found in previous studies may not have applied to this study's participants.

The two overarching themes discovered to be contributing factors on the impact of healthcare experiences for participants in this study were social work intervention and potential social work intervention. These factors were found to only have a positive impact on the healthcare experience for the study participants. All of the participants who reported having an encounter with a social worker during their healthcare visit reported the social work intervention as a positive experience. Participants in this study identified that social workers impacted their experience positively by directly providing or connecting them with needed resources, such as transportation and housing, and by providing them with information on and referrals to community resources.

Of the participants who stated they did not encounter a social worker, more than half stated they thought social worker intervention could have benefitted their healthcare experience. Participants expressed that social workers could potentially impact their healthcare experience by providing emotional support and by advocating for them. Social worker roles include those of

counselor, advocate, facilitator, and broker, among others. Social workers can provide individuals who are homeless with emotional support when faced with medical and psychological crisis. They can also provide emotional support through active listening and normalization of feelings when concepts that have a negative affect on patient's healthcare experience arise. Social workers can advocate for individuals who are homeless when they are in need of service connection or need assistance meeting requirements for discharge instructions. This can include situations where individuals are required to connect with specialist in other service areas or obtain medications with high co-payments. Social workers can advocate, on behalf of the patient, with medical staff to inquire about alternative means of meeting discharge instructions. Additionally, social workers can improve the healthcare experience for individuals who are homeless, in the role of broker, where they identify needed services and connect patients with resources. Within the role of facilitator, social workers, can bring the patient and the healthcare team together to discuss patient concerns and empower the patient to participate in creating their treatment plan. Social worker intervention could address the concepts found within this study to improve the healthcare experience for people who are homeless and contribute to overall better health and social outcomes.

Implications of Findings for Micro and Macro Practice

The findings from this study will help social workers improve the healthcare experience for individuals who are homeless through micro and

macro intervention. It is evident from this study's findings that social work intervention can have an impact on the healthcare experience for people who are homeless by means of increasing service connection. Essential roles of social workers, such as, counselor, advocate, broker, and facilitator are crucial for addressing concepts that impact the healthcare experience for individuals who are homeless. In addition, healthcare facilities are pivotal settings for social workers to make contact with individuals who are homeless. In this setting they have the opportunity to connect with this population to provide them with interventions such as, support, empowerment, and service connection.

In addition, social work engagement can address the other concepts that were found to impact the healthcare experience for individuals who are homeless, including time, perception of needs being met, and staff interactions. Social workers in the role of advocate and/or patient navigator can play a vital role in addressing the factor of time by providing patients with education on the process of patient intake and on the work flow of providing services in healthcare settings. In addition, social workers can assess for issues that may arise due to long wait times, such as lack of transportation or strict shelter intake times.

In regards to perception of needs being met, social workers can work with the medical team in the role of an advocate and/or patient navigator to ensure that the patient receives comprehensive education on the services they are receiving during their visit. Social workers can also pro-actively elicit the needs of homeless individuals and ensure that underlying social issues are assessed by

completing a psychosocial assessment. The completion of a psychosocial assessment would ensure that each individual's unique social needs are identified and specific resources are provided. Social workers could also seek out relationships with various community service organizations so that referrals could be made directly and followed up on promptly.

In regards to staff interactions, social workers can assist with improving staff interactions by providing staff with education on social barriers that are unique to this population. On a broader scale, social workers should advocate for mandatory diversity and cultural-awareness training for healthcare workers that includes working with the homeless population.

One major impact that the findings from this study have for social work practice is that it identified an area where social work intervention is needed but lacking. Research on social work roles in healthcare settings indicate that social work intervention most commonly comes at discharge (Judd & Sheffield, 2010). The role of discharge planner is most commonly found in inpatient settings. Of the participants in this study, 92% discussed their healthcare experience based on a visit to an outpatient setting. Participants reported seeking care at a healthcare facility as often as once every two weeks. Yet, only 40% of participants reported encountering a social worker during their visit. These findings indicate that there is a lack of social work intervention in outpatient settings where people who are homeless frequent more often. An earlier study conducted by Moore, Eckman, and Shumway (2012) found that patients in need

of social service intervention more often than not left without receiving a social work assessment. Findings from the current study indicate that that social workers should advocate for protocols in healthcare facilities that assign a social worker to outpatient settings such as urgent cares, family clinics, and hospital emergency rooms.

In addition, social workers should advocate for protocols that require each patient identified as homeless to receive a social services consult and/or psychosocial assessment during their visit. Identifying patients who are homeless at the time of visit can be done by incorporating questions about living situation or social situation into the facility's intake assessment. As previously noted, it was found in this study that not all individuals who are homeless will physically present in the stereotypical fashion. Indeed, participants in the current study, who had access to clothing, showers, and laundry facilities, presented as well kempt and may have been visually indistinguishable from other patients. Social work input on the creation of such questions would be beneficial in ensuring that the inquiries are non-stigmatizing and culturally sensitive.

Summary

This chapter started with a demographic description of study participants. Next the concepts developed during the open coding stage were presented, followed by the themes that were developed in the axial coding stage. Interpretations of the data were then discussed. The chapter concluded with a

description of the implications of the study findings for micro and macro social work practice.

CHAPTER FIVE

TERMINATION AND FOLLOW UP

Introduction

This study examined ways in which social workers could improve the healthcare experience for people who are homeless based on their perceptions of their healthcare experiences. This final chapter starts with a description of how termination of the study occurred. This is followed by how the study findings were communicated to the participants and the study site. Next, ongoing relationships with study participants will be discussed. Finally, the dissemination plan is explained.

Termination of Study

At the conclusion of each interview, the participant was thanked for their time and participation. The termination of the study at the study site commenced with the presentation of the findings. The termination of the study occurred when the final paper was submitted to the University.

Communication of Findings to Study Site and Study Participants

Communication of the study findings were submitted to the study site with an executive report. The study findings were communicated to the participants with an informational pamphlet to be distributed by the study site.

Ongoing Relationship with Study Participants

Termination with study participants commenced at the conclusion of the interview. The researcher did not have further contact with participants after the initial interview. Information pamphlets were submitted to the study site and made available at the study site for participants to access.

Dissemination Plan

The findings of the study were submitted to the University by means of a graduate studies research paper. Also, at the University, the final project was displayed at poster day.

Summary

This chapter began with a description of the termination of the study. This was followed by an outline of how the study findings were communicated to the study site and participants. Next, ongoing relationships with study participants (of which there are none) were discussed. This chapter concluded with a discussion of the dissemination plan.

APPENDIX A
DATA COLLECTION INSTRUMENT

Interview Questions

- 1) Have you ever been to a healthcare facility?
- 2) How often do you visit a healthcare facility?
- 3) There are different types of healthcare facilities (Hospital, Urgent Care, Clinics). What types have you visited?
- 4) Can you describe your experience as a patient at a healthcare facility?
- 5) Can you tell me about your interactions with the staff?
- 6) Social workers often work in healthcare settings. Did you encounter a social worker when you were a patient at a healthcare facility?
- 7) Did the social work effect your experience at the healthcare facility?
Did he/she make the experience better or worse?
- 8) Was your experience at the healthcare setting positive or negative?
What was positive about it? What was negative about it?
- 9) Do you feel there was anything a social worker could have done to improve your experience?
- 10) Do you have health insurance?
- 11) What is your gender?
- 12) What is your age?
- 13) What is your race?

APPENDIX B
INFORMED CONSENT



College of Social and Behavioral Sciences

School of Social Work

Participant Informed Consent

The study in which you are being asked to participate is designed to investigate how social workers can impact the healthcare experience for homeless individuals. This study is being conducted by McKinsey Kemp under the supervision of Dr. Gretchen Heidemann-Whitt, Professor of Social Work, California State University, San Bernardino. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

PURPOSE: The purpose of this study is to discover how social workers can improve the healthcare experience for homeless patients. This study will identify barriers homeless people face in accessing the resources they need to increase their chances of good health. Also the purpose of this study is to find ways that social workers can help to educate healthcare workers on working with homeless patients.

DESCRIPTION: After you sign the consent I will conduct the interview by asking you a few questions. These questions will be about things such as what type of healthcare setting you went to, how often do you visit a healthcare setting, and what were your experiences while you were there. At the conclusion of the interview I will give you time to ask questions.

PARTICIPATION: Your participation in this study is completely voluntary. If you decide you no longer want to participate in this study you can withdraw at any time. You can skip questions and do not have to answer any questions that you do not want to answer.

CONFIDENTIAL: Your participation in this research study is confidential. Your name will not be included in the research study or in the recorded data. A made up name or number will be used instead. Also the name of the site where the interview took place will not be named in the final paper. The audio on the digital recording device will be erased after it is downloaded onto a lab top computer and saved on a thumb drive. All data from the study will be saved here and will be deleted one year after the final paper is completed.

DURATION: As a participant you will only be expected to participate in one interview. The interview will be about 30 minutes. If you need to provide more information the interview can be extended but will not be longer than 45 minutes.

909.537.5501 · 909.537.7029

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

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College of Social and Behavioral Sciences

School of Social Work

RISKS: For this study there are no probable risks for participants.

BENEFITS: There are no direct benefits for participants as a result of this study,

AUDIO Recording: The interview will be recorded using an audio digital recorder. This recording will be used by the researcher for the purpose of this study only. This audio recording will be erased from the digital recorder after being downloaded to a computer lab top and saved onto a thumb drive. The thumb drive will be erased one year after the final paper is completed.

I understand that my interview will be audio recorded. Yes or No

CONTACT: For further questions about the research, research participant's rights, or in the event of a research-related injury please contact Dr. Gretchen Heidemann-Whitt, Professor of Social Work, California State University, San Bernardino by phone at (909)537-5501 or by email at Gretchen.Heidemann@csusb.edu

RESULTS: For results from this study please contact Dr. Gretchen Heidemann-Whitt after September 2018 by phone at (909)537-5501 or by email at Gretchen.Heidemann@csusb.edu.

CONFIRMATION STATEMENT:

I have read and understand the above information and agree to participate in your research study.

SIGNATURE: _____

DATE: _____

909.537.5501 · 909.537.7029

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APPENDIX C
PARTICIPANT RECRUITMENT FLYER



VOLUNTEERS NEEDED

VOLUNTEERS ARE NEEDED FOR A RESEARCH STUDY ON HOW SOCIAL WORKERS CAN IMPROVE THE HEALTHCARE EXPERIENCE FOR PEOPLE WHO ARE HOMELESS. INTERVIEWS WILL BE CONDUCTED BY A SOCIAL WORK STUDENT AND YOUR INFORMATION WILL NOT BE SHARED. PARTICIPANTS MUST 18 YEARS OF AGE AND NEED TO BE ABLE TO SPEAK AND UNDERSTAND ENGLISH.



DO YOU VISIT A
HEALTHCARE
FACILITY AT LEAST
ONCE IN A YEAR?

IF YES, THEN YOU
CAN VOLUNTEER
FOR A RESEARCH
STUDY

INTERVIEWS WILL
ONLY TAKE 30
MINUTES

YOUR TIME IS
APPRECIATED!!!

TIME AND DATES
(TO BE ADDED LATER
PENDING ON IRB
APPROVAL)

APPENDIX D
INSTITUTIONAL REVIEW BOARD

June 09, 2017

CSUSB INSTITUTIONAL REVIEW BOARD

Full Board Review

IRB# FY2017-177

Status: Approved

Ms. Mckinsey Kemp and Prof. Gretchen Heidemann

School of Social Work

California State University, San Bernardino

5500 University Parkway

San Bernardino, California 92407

Dear Ms. Kemp and Prof. Heidemann :

Your application to use human subjects, titled "Social Work Services: How can Social Workers Improve the Healthcare Experience for Homeless People?" has been reviewed and approved by the Institutional Review Board (IRB). The informed consent document submitted with your IRB application is the official version for use in your study and cannot be changes without prior IRB approval. A change in your informed consent (no matter how minor the change) requires resubmission of your protocol as amended through the Cayuse IRB system protocol change form. **Your application is approved for one year from June 09, 017 through June 08, 2018. Please note the Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study**

Your responsibilities as the researcher/investigator reporting to the IRB Committee include the following 4 requirements as mandated by the Code of Federal Regulations 45 CFR 46 listed below. Please note that the protocol change form and renewal form are located on the IRB website under the forms menu. Failure to notify the IRB of the above may result in disciplinary action. You are required to keep copies of the informed consent forms and data for at least three years. Please notify the IRB Research Compliance Officer for any of the following:

- 1) **Submit a protocol change form if any changes (no matter how minor) are proposed in your research protocol for review and approval of the IRB before implemented in your research,**
- 2) **If any unanticipated/adverse events are experienced by subjects during your research,**
- 3) **To apply for renewal and continuing review of your protocol one month prior to the protocols end date,**
- 4) **When your project has ended by emailing the IRB Research Compliance Officer.**

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval notice does not replace any departmental or additional approvals which may be required. If you have any questions regarding the IRB decision, please contact Michael Gillespie, the IRB Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

Best of luck with your research.

Sincerely,

Caroline Vickers

Caroline Vickers, Ph.D., IRB Chair
CSUSB Institutional Review Board

CV/IMG

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